STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBERT E LEE	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00113270. Complaint IN00113270 - Substantiated. Federal/State deficiencies related to the allegations are cited at F203 and F465. Survey dates: August 14, 15, 16, 17, 20, 21, 22, 2012 Facility number: 001145 Provider number: 155616 AIM number: 200120200 Survey team: Donna Groan, RN-TC Terri Walters, RN Dorothy Watts, RN Martha Saull, RN Carole McDaniel, RN (August 14, 15, 16, 17, 20, 22, 2012) Jennie Bartelt, RN (August 14, 15, 2012) Census bed type: SNF/NF: 57 Residential: 26 Total: 83 Census payor type:	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicare: 7 Medicaid: 42 Other: 34 Total: 83 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/28/12 by Suzanne Williams, RN			

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F0203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone			

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	number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. Based on interview and record review, the facility failed to ensure residents were informed in writing of required transfer or discharge information for 3 of 3 residents reviewed who met the criteria for transfers and discharges. Resident A, Resident B, Resident C Findings include: On 8/20/12 at 10 A.M., the SSD (Social Service Director) was interviewed regarding providing transfer/discharge information to residents. She indicated all residents' discharge papers should be in the closed clinical records. The clinical records of Resident A, Resident B and Resident C were reviewed at this time. Documentation was lacking of the residents having received the	F0203	F203 I. Residents A, B and C no longer reside at facility. II. All Residents discharge in the past 30 days have been mailed a copy of the Notice of Transfer or Discharge Form. All residents' discharge plans were reviewed to identify those residents with upcoming planned discharges and/or transfers. All Residents discharged since 8/22/ 2012 have been provided the Notice of Transfer or Discharge Form prior to discharge. III. Notice of Transfer or Discharge Form and information provided to residents and/or responsible parties at time of discharge were reviewed by QA committee and revised to include the LTC Ombudsman's information. The IDT were reeducated on the proper forms and information to be provided to all residents and/or responsible parties upon transfer or discharge. IV. The Social Services Director will review all discharged resident's clinical records to assure the Notice of Transfer or Discharge Form and pertinent transfer/discharge information is provided. The Social Services Director will report to QA committee weekly for four weeks, monthly for two months and quarterly thereafter. V. Completion Date: September 20,	09/20/2012

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	name, address and telephone number of the State Long Term Care Ombudsman. The SSD indicated Resident C was admitted to the facility on 6/29/12 and discharged on 7/3/12 to home with hospice services per the son's request who was Resident C's POA (power of attorney). The SSD indicated Resident B was admitted to the facility on 7/26/12 and discharged on 7/30/12 with hospice services. She indicated this resident is alert and oriented and independent in decision making. The SSD indicated Resident A was admitted to the facility on 7/23/12 and discharged on 7/26/12. She indicated after a care plan meeting on 7/26/12, the daughter, who was also his POA, decided to take him home immediately. On 8/20/12 at 4:17 P.M., the SSD was again interviewed. She indicated the facility did not complete a transfer/discharge form because the families of Residents A, B and C had requested to take these residents home, so appeal rights would not apply to them. The SSD indicated the family member of Resident A would not wait around to complete the transfer/discharge form. The SSD indicated the above residents and/or		2012	

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	representatives were not made aware of the local ombudsman information at the time of discharge. This deficiency related to complaint IN00113270. 3.1-12(a)(6)(A)(iv)			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure a resident in his room was not intruded on by another uninvited resident (Resident #84) for 2 of 2 residents who initiated verbal complaints. Resident #43 Resident #15 Findings include: On 8/14/12 at 3:28 P.M., during interview, Resident #43 indicated an elderly woman (Resident #84) comes into his room uninvited. At this time Resident #43 was observed to have a Velcro stop sign across his room door. Outside his room door, nursing staff. which included two CNAs. were passing ice water in his hall. The two CNAs had Resident #84 walking along with them as they passed ice water down the hall. On 8/16/12 at 10:45 A.M., Resident #84 was observed sitting inside the nurses' station in a regular chair with LPN # 56 working at the nurse's station.	F0241	F241 I. Resident #84 no longer resides at this facility. Resident #43 & #15 were interviewed to ensure they did not exhibit any signs or symptoms of anxiety secondary to another uninvited Resident entering their room. II. All other interviewable residents were interviewed with no concerns voiced regarding other residents wandering into their rooms. III. All staff were reeducated on dealing with the wandering resident and the protection of resident's dignity and privacy. IV. The Social Services Director will also conduct random audits during normal business hours to identify any future concerns any other resident wandering into other residents' rooms. These audits will be conducted with 3 random residents. These audits will be conducted weekly for four weeks and monthly thereafter. The Social Services Director will report to the QA Committee weekly for four weeks, monthly for two months and quarterly thereafter. V. Completion Date: September 20, 2012	09/20/2012

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On 8/17/12 at 9:35 A.M., Resident #43 stated he would like Resident #84 (he gave her room number) to stay out of his room. The Director of Nursing (DON) was walking by and was informed of what Resident #43 had requested. The DON indicated at this time "I know."

On 8/20/12 at 8:50 A.M., Resident #84 was observed walking on the back unit of the facility (not her unit) by herself and entered into an unoccupied resident room on this unit. The Social Service Director (SSD) was made aware of Resident #84 in an unoccupied room. The SSD entered the room and assisted Resident #84 to ambulate back to her unit.

On 8/20/12 at 9:20 A.M., during interview with the SSD, she indicated Resident #43 had the Velcro stop sign across his resident room door to stop Resident #84 from entering his room uninvited. She also indicated Resident #84 had gone in Resident #43's room and looked under his bed.

On 8/20/12 at 10:15 A.M., Resident #15 verbalized Resident #84 had just come out of his bathroom. Resident #84 was at that time observed in the

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	hall outside Resident #15's room. Resident #15 indicated he wanted this resident to stay out of his room. He also indicated Resident #84 had been in his room this a.m. around 3:00 A.M. 3.1-3(t)			

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F0248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on record review, interview and observation, the facility failed to ensure the resident's current interests for activities were offered by the activities program, for 1 of 3 residents reviewed for activities of 10 who met the criteria for activities. (Resident #75) Findings include: The clinical record for Resident #75 was reviewed on 8/16/12 at 2:15 p.m. The resident's diagnoses included, but were not limited to, dementia, obsessive compulsive disorder and mood disorder with psychosis. The resident was admitted on 9/9/11. The Activity Assessment dated 9/9/11 included, but was not limited to "Current Interests crafts, exercise, music, reading, baking, shopping, gardening, radio, and watches TV." A Psychotherapy Progress Note dated 7/18/12, indicated the "Plan" included, but was not limited to,	F0248	F248 I. The activity plan for Resident #75 has been reviewed and revised by the IDT. II. Activity plans for all residents were reviewed and found to be appropriate based on documented assessments of activity preferences. III. The activity staff will be reeducated on assessment, planning and documentation of activity preferences and participation. The Activity Participation form was reviewed by QA committee and has been revised to indicate resident refusals of offered activity participation. The Social Services Director will be reeducated on communicating any activity related psychosocial referrals with Activities department. IV. The IDT will review each resident's activity plan during the quarterly care plan conferences and with any significant change in status. The Activity Director will review resident participation records monthly and report audit findings to QA Committee monthly for three months and quarterly thereafter. V. Completion Date: September 20, 2012	09/20/2012

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	"Encourage more activity." On 8/20/12 at 9:30 a.m., in interview with the ADON (Assistant Director of Nursing) she indicated any recommendations from the Psychotherapist goes to Social Service, and she gets the information back to nursing. On 8/20/12 at 4:15 p.m. the Social Service Director indicated the Psychotherapy Progress Note Plan was the therapist's plan. The Activities Care Plan, dated as revised on 5/1/12, included, but was not limited to; Prefers to: have books, prefers to read, listen to music, do things with groups of people, participate in religious services, Independent with decision making et (and) Independent with leisure time. Approach: Needs invitations et reminders of group activities. Invite to group activities; Assist outside prn x's weekly during good weather; Invite to all Protestant services, Invite to music activities enjoys country /western, rock-n-roll, Symphonic. During interview on 8/16/12 at 2:50 p.m., QMA #1 was not aware if the resident attended activities .			

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	In interview with LPN #20 on 8/16/12 at 2:55 p.m., she indicated the resident stays in the room per the residents choice. "The resident will now and then attend the activities." In interview with the Activities Director on 8/17/12 at 7:50 a.m., he indicated he keeps a calendar for the resident. The August 2012 calendar indicated the resident was visited on Aug. 3 at 1:30 p.m. ice cream social, and Aug. 4, 7, 11 and 14 at 3 p.m. popcorn visit to room. At this time, the Activities Assistant indicated no 1:1 visits were done. The Activity Director indicated a response to activities offered was not documented. He indicated he "goes to the room and tries to get the resident to attend." He indicated music programs were offered. "The resident doesn't want to come out. I guess we need to document the resident declined and haven't been documenting this." He was not aware of the Plan by the Psychotherapist to "encourage more activity." Review of the August Activity Calendar, at this time, lacked any crafts, baking and/or gardening being offered, and music was offered on 8/15, 8/22, and 8/29/12.			

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During interview on 8/17/12 at 8 a.m., the Activities Assistant indicated "the resident doesn't like to talk, doesn't want you in the room. She used to come out for meals and doesn't want to be bothered. We go in the room for popcorn visits and ice cream social."

On 8/15/12 between 8:30 a.m. and 9:30 p.m. the resident was observed lying in the bed watching TV. The Activities Calendar listed 9:00 a.m. Coffee Corner in the Activity Room.

On 8/17/12 at 10:15 a.m., the resident was observed lying in the bed with the TV on. At 10:30 a.m., on 8/17/12, the Activities Calendar indicated Awakening was to be held on the 1-2-3 hall. The resident was not observed in the activity. Residents were observed passing around a balloon.

The last Activity Note dated 5/1/12, indicated "Res. up ad lib in room et facility. Alert with severe cognitive impairment. Res HOH (hard of hearing) et is repetitive with verbalization. Res. tends not to listen to peers just cont (continues) to repeat what she says. Res eats meals in DR (dining room) et is very

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	particular about what she eats. Res. is at risk for elopement et wander guard in place at all x's d/t decreased safety awareness. Res. usually attends outing shopping monthly to Wal-mart with staff 1:1 assist. This past month res. sent list along with AA (Activities Assistant) for her to buy needed items. Res. spends leisure x (time) in room watching TV in room - sitting in her rocker et sorting thru her craft stuff et other materials. Res. prefers own room for leisure x. Act. staff provides popcorn visits 2 x weekly. No concerns at this x. Proceed with Plan of Care." The Activity Director, in interview on 8/20/12 at 1:50 p.m., indicated the care plan had been revised and activities staff will document on the monthly calendar of attendance at group activities. 3.1-33(a)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview and record review, the facility failed to ensure adequate supervision to prevent wandering behaviors which included into other resident rooms and a witnessed elopement for 1 of 1 resident observed with wandering behavior. Resident #84 Resident #84's wandering behavior affected 5 other residents randomly observed and interviewed. Resident #47, Resident #15, Resident #43, Resident #39, Resident #30 B. Based on observation, interview and record review, the facility failed to ensure fall prevention devices were monitored and/or utilized for 1 of 3 residents reviewed for falls of 5 who met the criteria for falls. Resident #5 Findings include: A. The clinical record of Resident	F0323	F323 I. Resident #84 no longer resides at this facility. Residents #15, #30, #39, #43 & #47 were interviewed to ensure they did not exhibit any signs or symptoms of anxiety secondary to another uninvited Resident entering their room. Resident #5 has been reassessed for fall risk and her care plan has been updated. II. All residents were reassessed for elopement risk. Those identified as high risk for elopement were identified. All interviewable residents were interviewed with no concerns voiced regarding other residents wandering into their rooms. All orders for personal alarm devices were reviewed. Those residents with orders for personal alarm devices were identified. III. Wanderguards were changed and dated for all residents identified as high risk for elopement and this documentation was entered into each resident's Treatment Administration Record. The facility's Missing Resident Policy was reviewed by QA committee and found to be appropriate. All staff will be reeducated the facility's Missing Resident Policy	09/20/2012

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	#84 was reviewed on 8/16/12 at 2 P.M. Diagnoses included, but were not limited to, the following: dementia of Alzheimers type with disturbances of behaviors . Review of the Minimum Data Set Assessment dated 7/12/12 included, but was not limited to: cognition, moderately impaired, decisions poor, cues/supervision required, no behaviors documented, limited assistance for ambulation on and off unit. A care plan dated 4/12/12 addressed the problem of "high risk for elopement: due to: Dementia, decreased safety awareness and ambulatory." 4/13/12: Resident emotional upset due to wanderguard on wrist. 5/3/12: Resident wanders, will go into other resident's rooms trying to find her room, especially ones near her room. Interventions included, but were not limited to, the following: attempt to redirect, assess for hunger, toileting needs, pain, etc. assist as needed, make all staff aware of wander risk, (5/3/12) stop		and Procedure and on dealing with the wandering resident and the protection of resident's dignity and privacy.. All nursing staff will be educated on fall prevention alternatives and personal alarm devices. IV. The Director of Nursing or designee will audit wanderguard placement, dating and documentation for all high elopement residents initially, then weekly for four weeks and monthly thereafter. The Social Services Director will also conduct random audits during normal business hours to identify any future concerns any other resident wandering into other residents' rooms. These audits will be conducted with 3 random residents. These audits will be conducted weekly for four weeks and monthly thereafter. The Director of Nursing or designee will monitor personal alarm placement and response time. These audits will be unannounced on all shifts on random residents. These audits will be conducted for four residents weekly for four weeks, monthly for two months and quarterly thereafter. The IDT will review fall prevention interventions during quarterly care plan meetings, with any significant change in resident condition and with any fall. The Director of Nursing, IDT, Social Services Director and/or designee will report to QA committee weekly for four weeks, monthly	

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	155616	A. BUILDING 00 B. WING	08/22/2012

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	sign put on other resident's room for boundaries. A care plan dated 7/9/12 addressed the problem of "resident wanders in and out of others rooms. Res (resident) will pick out one rm (room) and then continually go to that rm." Interventions included, but not limited to, the following: "stop sign applied to door of res rm for boundary." An elopement risk assessment form was dated 7/12/12 and indicated the resident was at high risk for elopement. This form indicated the resident was cognitively impaired with poor decision making skills, has a diagnosis of dementia, is able to ambulate independently and wanders aimlessly. A self reported incident from the facility to the Indiana State Department of Health was dated with occurrence date of 8/12/12 at 11:20 A.M. This form indicated the following summary findings: "Facility substantiates that Resident was on facility grounds, witnessed by a		for two months and quarterly thereafter. V. Completion Date: September 20, 2012	

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	housekeeper. Housekeeper witnessed Resident follow church visitors out...doors. Staff responded immediately to resident to redirect indoors..." On 8/14/12 at 11:12 A.M. a current copy of the CNA (certified nursing assistant) assignment sheet for Hall 4 was received from LPN #44. This form indicated the following for the resident: mobility: wheelchair; adaptive equipment: confused likes to look at magazines, elopement risk. On 8/14/12 at 2:39 P.M., Resident # 47 was interviewed. He indicated the following in reference to other residents in the facility: "...She (Resident #84) comes to my room and gets into my things and looks at my things. She gets into my stuff. I take it the staff know about her." On 8/14/12 at 3:28 P.M., Resident #43 was interviewed. He indicated an elderly woman named (name of Resident #84) comes in his room. Resident #43 was observed to have a mesh stop sign, which extended			

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	across his doorway and attached with velcro to each side of the door frame. This stop sign was at chest height for a 5 foot 2 inch person. On 8/16/12 at 10:45 A.M., Resident #84 was observed sitting behind the nurses station while LPN #56 was also sitting at the nurses station. On 8/16/12 at 11:30 A.M., Resident #84 was walking down the Hall 4 with a blanket around her shoulders and then went to sit at the nurses station. Hall 4 is the nursing unit located at the opposite end of the building from the Halls 1,2,3. Hall 4 is visually out of view from Halls 1,2,3 and/or the nursing station for this unit. Resident #84's room is located on the short hall on unit 4. On 8/16/12 at 3:22 P.M., Resident #84 was observed wandering around the skilled unit on Halls 1, 2, 3. Housekeeper #67 was standing in the hall and acknowledged Resident #84. Resident #84 then followed Housekeeper #67 down Hall 3. Resident #67 walked down hall 3			

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	toward the nurses station. Resident #84 stood in the doorway in Hall 3 of a resident room who had the call light sounding. CNA #77 asked Resident #84 not to go into a resident room. The CNA (certified nursing assistant) continued walking down the hall. Now Resident #84 is following CNA #77. On 8/17/12 at 7:43 A.M., Resident #84 was observed in the dining room eating breakfast. She had her pajamas on and a blanket around her shoulders, resembling a shawl. This dining room is located on unit 4. On 8/17/12 at 7:45 A.M., the resident was observed wandering around unit 4. At 7:51 A.M., Resident #84 was observed walking into her room. The DON (Director of Nursing) went into the resident's room and brought her back out to where she had been sitting in the dining room. At 8 A.M., the resident was observed standing beside her table in the dining room. Resident #84 then began reaching into her tablemate's food while the tablemate was still eating. Resident #84 had her hands in the tablemate's			

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	biscuits and gravy, while the tablemate was eating cereal. The DON came over to the table, wiped Resident #84's hands and then took Resident #84 back to her room. As the DON came out of Resident #84's room, the resident immediately followed the DON. At 8:10 A.M., the resident was back in her room, then out in the hall a minute later. At 8:15 A.M., Resident #84 wandered into room #108. No residents were in this room at the time. Housekeeper #67 was in the hall and coaxed Resident #84 out of the room. Resident #84 went in the dining room. At 8:17 A.M., Resident #84 went in room 112. CNA #76 walked by and coaxed Resident #84 out of the room. At 8:23 A.M. Resident #84 was observed wandering on the hall of the opposite end of unit 4. At 8:30 A.M., Resident #84 was observed in the doorway of Resident #43. CNA # 76 went over to the resident and called her by name. Both the CNA and Resident #84 were out of sight for a minute before leaving the resident's room/doorway. Resident #43's door was then observed closed with the velcro stop sign over the door. At 8:43 A.M. Resident #84 was			

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	observed still wandering about unit 4, including through the nurses station. She was observed ambulating up to groups of staff who were standing and talking in the halls. Resident #84 would just stand beside these groups of staff. On 8/17/12 at 9 A.M., Resident #84 was observed walking into the room of Resident #47. No residents were in this room at the time. This is the hall at the opposite end of the unit Resident #84 is housed in. Resident #84 came out of this room and went a few doors down to the room of Resident #43 again. At this time, the door was opened and the stop sign was down. Resident #43 was out of his room at this time. Resident #84 came out of this room and then began following LPN #22. Resident #84 then was observed to walk into the room of Resident # 39, who was in the bed at the time. On 8/17/12 at 9:35 A.M., Resident #43 was observed in the hall in his wheelchair, outside of Resident #84's room. Resident #43 indicated he wanted Resident # 84 told to stay out of his room. The DON was walking by and was informed of what Resident #43 just stated. The DON replied "I know."			

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	On 8/17/12 at 10:43 A.M., Resident #84 was observed ambulating by the unit 4 dining room and passed the ADON and the DON in Hall 1. Resident #84 was then observed to ambulated to the opposite end of the building from where she was housed, to the back unit, with halls 1, 2 and 3. On 8/20/12 at 8:50 A.M., Resident #84 was observed walking on hall 1, 2, 3 by herself. At this time, the resident was observed to walked in room #29. At this time, Room #29 was observed to be unoccupied. Room #29 is on the unit at the opposite end of the building from Resident #84's room. At this time, the SSD (Social Service Director) was on this unit and was made aware of the resident being in Room #29. The SSD then was observed walking with the resident back to hall 4. On 8/20/12 at 10:15 A.M., Resident #15 was interviewed. He stated Resident #84 just came out of his bathroom. Resident #15 indicated he wants Resident #84 to stay out of his room. Resident #15 stated Resident			

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	#84 came in his room around 3 A.M. this morning. Resident #15 is currently in contact isolation. On 8/20/12 at 11:50 A.M. a copy of the current TAR (Treatment Administration Record) for Resident #84 was received from the Medical Records staff member. This form was lacking documentation of the resident's wanderguard being changed and/or the date it was due to be changed. The TAR did indicate the following for this resident: "May apply wanderguard for safety. Check for placement and function every shift." This was documented as done every shift for the month to date. Nurses notes were reviewed on 8/20/12 at 12 P.M. for the dated of 8/11/12. Documentation was lacking of the wanderguard having been changed on that date. On 8/20/12 at 11:55 A.M., the policy and procedure for "Missing Resident Policy and Procedure" was received from the DON. This policy had a revision date of 5/11/10 and included,			

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	but was not limited to, the following: "wanderguard will be applied, date of activation and application will be written on the wanderguard device; date of activation and application will be written on the resident's Treatment Administration Record...wanderguard devices will be replaced every 90 days and as needed..." On 8/20/12 at 12:20 P.M., LPN #56 was interviewed. She stated she changed the resident's wanderguard to her right ankle from her wrist as the resident tried to cut off her wrist wanderguard with her butter knife. At this time, the wanderguard bracelet was observed to the resident's right ankle, with no date on it. LPN #56 indicated she changed the wanderguard bracelet from the resident's wrist to her ankle on 8/11/12. She indicated she applied a new bracelet to Resident # 84 because the bracelet was damaged due to the resident trying to get it off. LPN #56 stated she didn't know she was to dated the wanderguard bracelet on the resident when it was applied. On 8/20/12 at 12:30 P.M., the ADON and DON were interviewed. They			

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	indicated the resident originally had the wanderguard put on, on 4/12/12 and this was because she was becoming more confused and spending more time around the doors. At this time, the DON stated she didn't see documentation in the clinical record of the resident's bracelet being changed since application initially on 4/12/12. The DON stated it should have been documented on the TAR (treatment administration record) the last time the wanderguard was changed, but she was unable to find documentation of this being done. On 8/22/12 at 8:10 A.M., the ADON and DON were interviewed. They indicated regarding Resident #84, they do not monitor and/or track the resident's wandering behaviors. On 8/22/12 at 8:40 A.M., the SSD (social service director) was interviewed. She indicated the facility doesn't track and/or have a monitor in place for the resident in regard to her wandering behaviors. She indicated the facility has a box of items in the dining room to keep the resident busy. She indicated the resident			

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	does follow staff around throughout the facility. B. The clinical record of Resident #5 was reviewed on 8/16/12 at 2 P.M. Diagnoses included but were not limited to dementia, weakness and unsteady gait. Review of the most recent Minimum Data Set Assessment dated 7/17/12 included, but was not limited to: total cognitive score was 10 which indicated moderately impaired cognition; assistance with transfers was 2 - limited assistance, res highly involved in activity, staff provide guided maneuvering of limbs or other non weight bearing assistance. Locomotion on and off unit: walk in corridor and in room with transfer assistance of 1 (supervision/oversight, encourage or cueing); mobility device walker/wheelchair; balance during transfer and ambulation - 2 (not steady walking, turn around and face opposite direction while walking). Falls indicated "Yes". Falls since admission: one with an injury.			

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A care plan dated 2/6/12 indicated the following: At risk for falls. Interventions included but were not limited to the following: w/c (wheelchair) alarm (4/7/12), educate /remind resident to request assistance prior to ambulation.

The fall risk assessment was completed on 4/7/12 and indicated the resident had a total score of 10, which indicated she is a high risk for falls. This form indicated the resident had a history of falls, balance problem while standing and walking, jerking and making unstable turns and required assistive device of a wheelchair and well as two predisposing diseases.

On 8/14/12 at 3:30 P.M. Resident #5 was observed in her room in her wheelchair. The pull tab alarm was not attached to the resident but the alarm box was attached to the resident's chair. At this time, CNA #78 came into the room, to give the resident ice water. CNA #78 didn't check the alarm attachment. At 4:30

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	P.M., the resident was still in her wheelchair with the tab alarm not attached to the resident. At 5 P.M., the resident was in the dining room in her wheelchair. LPN #25 was asked to check placement of the pull tab portion of the alarm. At this time, LPN #25 did reattach the pull tab portion to the resident. On 8/17/12 at 7:50 A.M. Resident #5 was observed in the dining room with a pull tab alarm to back of her wheelchair but the pull tab portion of the alarm was not attached to the resident but was laying down back inside of wheelchair. On 8/17/12 at 12:07 P.M., the ADON was informed that Resident #5 had been up and about ambulating in her room without the pull tab alarm on. The resident was in the bathroom in her wheelchair with no alarm attached to her. The ADON was made aware the alarm was on the wheelchair, just not attached to the resident. The Resident was observed at this time to have used the toilet and was flushing it. At this time, the ADON was interviewed and indicated the resident was supposed to have to have an			

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	alarm on while in the wheelchair. On 8/21/12 at 9:25 A.M., the DON was interviewed. She indicated she changed this resident to a pressure alarm in her wheelchair instead of the tab alarm. She indicated the resident had fallen in April of 2012 and received the pull tab alarm in her wheelchair on 4/7/12. She indicated the most recent fall of the resident was on 6/7/12. On 8/22/12 at 8:25 A.M. and alarm was heard sounding by a visitor from inside a room with the door closed. The alarm had been sounding for at least a minute. After the visitor moved into the hall, the alarm was heard louder. No staff were observed in the hall directly in the area of the alarm sounding. At this time, a second visitor was observed in the hall of the room of Resident # 5 where the alarm was sounding. The visitor went to find staff to respond to the alarm. At 8:26 A.M. , the visitor did notify the Medical Record staff member, who was at the nurses station down the hall. The resident was observed in her bathroom with the door closed with the pressure pad alarm sounding from her wheelchair.			

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	The resident was sitting on the toilet by herself. By 8:27 A.M., the Medical Record staff member was at the resident's side assisting her. 3.1-45(a)(2)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure expired produce was discarded timely, food items and kitchen supplies were stored off the floor, and wall fixtures were free of dust and soil for 1 of 2 kitchen tours. This had the potential to impact all 56 residents receiving meals at the facility. Findings include: On initial tour on 8/14/12 at 11:00 A.M., the kitchen area was toured with the Food Service Manager (FSM). In the walk in refrigerator, 20 heads of lettuce and one bag of romaine lettuce were observed to have brown discoloration scattered throughout the lettuce leafs and cores. The manufacturer's date on the lettuce was 7/31/12. The FSM indicated she was going to throw out	F0371	F371 I. Discolored lettuce was discarded. All perishable food items were checked for freshness. All expired or discolored items were discarded. Mobile steam table was cleaned. Walls and surfaces in the kitchen were cleaned. Food storage room floor was cleaned. Boxes were removed and stored off of the floor. II. A tour of the kitchen was conducted by the Administrator and no other produce was identified as discolored. All areas were assessed for cleanliness and identified areas were cleaned. III. The dietary staff will be reeducated on food storage and sanitation. Specialty racks were purchased and to provide elevation from floor for future storage. IV. The Dietary Supervisor will monitor food storage and sanitation daily. Identified issues will be corrected immediately. The Administrator will conduct unannounced rounds to audit produce and food storage. These audits will be conducted daily for two weeks, weekly for two weeks, monthly for two months and quarterly thereafter. The Dietary Supervisor and Administrator will report to QA committee weekly for four weeks, monthly for two months and quarterly thereafter. V. Completion Date: September 20, 2012	09/20/2012

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	155616	A. BUILDING 00 B. WING	08/22/2012

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	the 20 lettuce heads and bag of romaine lettuce. A mobile steam table that was transported to different dining rooms in the facility had dried food particles in the bottom of all four pans. One wall in the kitchen had a thermostat and gray pipe fixture that was directly above a crate of stored drinking glasses. The thermostat and gray pipe had a film of dust and debris Next to the stove a large fryer appliance had a sticky film and debris on the knobs and outer surface of the appliance. On 8/14/12 at 11:31 A.M., in the food storage room the floor was heavily soiled with a black debris and sticky when a hand was swiped across it. Four large cardboard boxes were observed on the floor which contained napkins, Shasta soda, Thick and Easy food thickener, and Campbell soup. The FSM indicated at this time, the food items and supplies should not be on the floor. She also indicated the floor was soiled.			

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	On 8/20/12 at 10:37 A.M., documentation from the FSM entitled, " Quick Kitchen Sanitation Rounds " was reviewed. This form indicated the dietary manager should look at the following items daily: " ...2. Food Storage storeroom: No dented cans, Nothing stored on the floor ... " " ... 5. Environment : floor is clean and without build up ... " On 8/21/12 at 11:17 A.M., during interview with the FSM, she indicated if produce has brown areas then produce needs to be gotten rid of. 3.1-21(i)(3)			

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F0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure drugs were labeled for 1 of 27 residents who resided on Hall 1, 2,	F0431	F431 I. Unlabeled medications were discarded. Medication room door locks were assessed by Maintenance Director and found to be fully operational. II. All	09/20/2012

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	and 3, and stored and protected from unauthorized access on Hall 4 which had the potential to affect 29 residents. Findings include: On 8/21/2012 at 10:50 P.M., during an inspection of the medication cart located on unit 1-2-3, 7 tablets were observed in a medication cup in the top drawer of the medication cart. No identification as to whom the medication belonged or the type of medication was observed on the cup. LPN #11 indicated the pills belonged to a resident who had refused his medications earlier that day. LPN #11 said, "Those pills should have been disposed of as soon as the resident refused them for the 3rd time." Review of the facility's undated Policy and Procedure for medication refusal on 8/22/2012 at 9:00 A.M., reads as follows "...if the resident refuses medication again the medication will be placed in the locked medication cart and offered one additional time. If more than one resident refusing		Medication Administration Records were reviewed and those residents receiving and having medication stored by the facility were identified as at risk. III. The facility's policies for Medication Administration and Storage and Medication Room Security were reviewed by QA committee and found to be appropriate. Licensed nurses will be reeducated on Medication Administration and Storage Policies and Medication Room Security Policy. IV. The Director of Nursing or designee will conduct unannounced audits of medication carts and medication room. These audits will be conducted daily for two weeks, weekly for two months and quarterly thereafter. The Director of Nursing or designee will report to QA Committee weekly for four weeks, monthly for two months and quarterly thereafter. V. Completion Date: September 20, 2012	

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	during a single medication pass, the Resident's name must be placed on the medication cup for identification...." On 8/21/2012 at 3:05 P.M., during an interview with the Assistant Director of Nursing, she said, "They know better than that. When medications are refused, they need to be disposed of immediately. " 2. On 8/20/12 at 3:15 P.M., CNA #10 was observed to approach LPN #5 and request her medication room keys "So I can put my purse in the med room." The LPN provided her keys to the CNA. The CNA proceeded down the hall and out of view, accessing the medication room and closed the door behind her. She remained in the medication room with her purse alone for 3 minutes before returning the keys. On 8/20/12 at 4:15 P.M., the Director of Nursing was interviewed and informed of the occurrence. She indicated it was the facility Policy that only those licensed for drug handling			

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	be permitted to be in the medication rooms unattended. She indicated the policy was well known to the nursing staff and provided the undated corresponding policy. 3.1-25(o)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A. Based on observation, interview	F0441	F431 I. Unlabeled medications were discarded. Medication room	09/20/2012

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	and record review, the facility failed to ensure infection transmission precautions were followed on 1 of 2 units for 1 of 1 resident with contagious infection with a potential to affect 29 residents who reside on the unit. Resident #15 B. Based on interview and record review, the facility failed to use the proper bactericidal solution and the training to utilize the solution correctly on 1 of 2 units. Unit #1 Findings include: A1. During observation on 8/15/2012 at 10:08 A.M., a contracted Psychotherapist entered Resident #15 ' s room and sat down in the resident ' s wheelchair and started conversing with the resident. This resident was designated for contact isolation due to penile drainage that was positive for antibiotic resistant bacteria. There was a sign on the door frame directing visitors to see the nurse before entering the room. It was observed the Psychotherapist did not have gloves or gown on during		door locks were assessed by Maintenance Director and found to be fully operational. II. All Medication Administration Records were reviewed and those residents receiving and having medication stored by the facility were identified as at risk. III. The facility's policies for Medication Administration and Storage and Medication Room Security were reviewed by QA committee and found to be appropriate. Licensed nurses will be reeducated on Medication Administration and Storage Policies and Medication Room Security Policy. IV. The Director of Nursing or designee will conduct unannounced audits of medication carts and medication room. These audits will be conducted daily for two weeks, weekly for two months and quarterly thereafter. The Director of Nursing or designee will report to QA Committee weekly for four weeks, monthly for two months and quarterly thereafter. V. Completion Date: September 20, 2012	

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	the session in Resident #15 ' s room. On 8/15/2012 at 10:02 A.M., during interview, LPN #10 indicated contact isolation procedures required one to use gown and gloves when sitting down or touching anything in Resident #15's room. On 8/15/2012 at 10:35 A.M., during an interview with the Psychotherapist, after he had exited Resident #15's room he indicated he was very familiar with isolation precautions. He indicated he had seen the sign on the door frame and that he was aware which residents were on isolation precautions. He said, "I don't need to gown up because I don't deal with any bodily fluids." Lacking awareness of infection transmission precautions, he then proceeded down the hall into another resident's room. On 8/17/2012 at 2:00 P.M., review of the physicians order dated 7/6/2012 indicated "...Re-culture penile drainage 2 days after antibiotic completion...."			

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	The facility's Policies and Practices - Infection Control, were reviewed on 8/16/2012 at 2:30 P.M., Policy and Interpretation and Implementation: (b) Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. (c) Establish guidelines for the implementing Isolation Precautions, including Standard and Transmission-Based Precautions. On 8/16/2012 at 3:00 P.M., review of the Transmission-Based Precautions per CDC guidelines provided by the facility for contact isolation read as follows: 1. Wear gloves whenever touching the patient ' s intact skin or surfaces and articles in close proximity to the patient (e.g., medical equipment, bed rails). Don gloves upon entry into the room or cubicle. 2. Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the patients care environment. After gown removal, ensure that clothing			

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	and skin do not contact potentially contaminated environmental surfaces that could result in possible transfer of microorganism to other patients or environmental surfaces. On 8/21/2012 at 10:05 A.M., during an interview the Social Service Director, she indicated the facility has a contracted agreement with a psychotherapy service. She indicated she would meet with the members of the service prior to their entry to the facility and identify those residents on isolation precaution. The Social Service Director said, "They don't deal with any body fluids; they just sit there and talk." On 8/16/2012 at 3:00 P.M., during an interview with the Assistant director of Nursing she provided a list of the residents located on Hall 4 that were on isolation precautions. They were as follows: 1 resident with Methicillin Resistant Staphylococcus Aureus (MRSA), 4 Residents with Clostridium Difficile (C-diff). B1. On 8/21/2012 at 1:45 P.M.,			

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	during interview with Housekeeper #3 on Hall #4 (short hall), she indicated she used Oxivir Five 16 concentrate when she mopped the floors of the residents' rooms, including the rooms with isolation precautions. She said she changed the water after she mopped the isolation rooms. On 8/21/2012 at 9:20 A.M., during interview with Housekeeper #4, she indicated she used a full cap of Dispatch Bleach Germicidal Cleaner in her mop bucket. She said, "I don't not know exactly how much to use for a bucket of water." On 8/21/2012 at 9:10 A.M., the Floor Tech indicated he was unsure if he should use 2 or 3 ounces of Dispatch in his mop water. He indicated the previous Housekeeping supervisor told him to use 4 ounces. He said that, as far as he knows, the portion of Dispatch to use in relation to water volume is not written anywhere. On 8/21/2012 at 8:35 A.M., a service tech for the manufacturer of Oxivir Five 16 concentrate, an			

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	industrial/institutional, disinfectant cleaner indicated, during a phone conversation, only bleach will kill C-Diff bacteria, and Oxivir is a hydrogen peroxide based product which will not kill C-Diff bacteria. 3.1-18(b)			

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F0465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. A. Based on observation, record review and interview, the facility failed to provide sanitary areas and appliances on 2 of 2 units. This deficient practice had the potential to affect 56 residents who resided on Unit 1-2-3- and Unit 4. B. Based on observation, interview, and record review, the facility failed to ensure floors were clean in the food storage room of the kitchen, the floor area near the kitchen exit door, and the floor area which contained pan storage shelving for 2 of 2 kitchen tours. This deficient practice had the potential to affect 56 current residents and 26 residential residents. Findings include: A1. On 8/20/12 from 9:00 A.M. to 9:20 A.M., the Unit 1-2-3 environment was observed. The Pantry on that unit had counter and food prep area soiled with accumulated dried food matter and lose soil and debris. The microwave oven interior was caked with food spatter, oil and burned charred material. It had an	F0465	F441 I. Contracted Psychotherapist was educated on proper infection control practices. All housekeeping employees were educated on proper dilution and use of bactericidal agents. II. The clinical records were reviewed and those residents who receive contracted psychotherapy services were identified as at risk. In addition, all residents are at risk due to the provision of housekeeping services. III. The facility's Infection Control Policies and Procedures were reviewed by QA committee and found to be appropriate. All contracted therapists will be educated on proper infection control practices. All housekeeping employees will be reeducated on Infection Control practices that will include but not be limited to the proper dilution and use of bactericidal agents. IV. The Director of Nursing or designee will monitor the infection control practices of contracted therapists during therapists visits. The Administrator or designee will audit the dilution and use of bactericidal agents daily during walking rounds. The Director of Nursing, Administrator and/or designees will report to QA Committee weekly for four weeks, monthly for two months and quarterly thereafter. V. Completion Date: September 20, 2012	09/20/2012

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	objectionable rancid character. The exterior control panel and door handle had visible accumulated hand soil and dried food matter. The pantry floors were discolored with accumulated soil, dried food mater, loose food soil and debris which had accumulated especially around edges and in corners. The floor of the nurses station was heavily soiled with accumulated loose dirt and debris in corners and edges and dried spills and spatters had accumulated soil and hair which was visible in chair wheel housings. There were 3 of 3 chairs which had ripped, worn and torn upholstery. Cabinetry was heavily soiled and discolored on drawer and door facings and edges. Maroon colored resident charts were all soiled with enough accumulated hand soil to obscure the color and surface imprint with brown matter and produced a tacky residual feel of soil with handling. A2. On 8/20/12 from 9:25 A.M. to 9:45 A.M. the Unit 4 environment was observed. The pantry area floor had heavy accumulated soil. The microwave interior surfaces were visually obscured with deep layers of dried food, oil and adhering matter.			

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	The interior odor was with a sour spoiled food odor. Exterior surfaces were also soiled with food matter and grease and the top had a thick layer of dust and soil. The floor was heavily soiled throughout with loose soil, dust, hair and debris. The nurses station floor was heavily soiled with dirt both loose and adhered and dirt and debris accumulated around edges and oiled in corners. The flooring surface was worn, marred, scarred and scratched. There were 3 of 3 chairs which were heavily soiled and had torn, worn upholstery. Cabinetry which had been light colored was heavily soiled to charcoal gray and shaded darkest in hand contact areas and edges. Resident charts were heavily soiled in hand use areas with matter lodging in vinyl imprint creating a coating of soil. A3. On 8/20/12 at 9:15 A.M., LPN #20 indicated she thought maybe medical records department was going to start cleaning charts since that person just assumed that position. The LPN indicated she was not aware of any ongoing chart cleaning done on a routine basis but indicated the charts were in constant use by staff of every discipline.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	08/22/2012

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	A4. On 8/20/12 at 1:00 P.M. the Director of Nursing (DON) was interviewed and indicated the housekeeping department was responsible for cleaning the nurses stations and pantries and the Medical Record Director was going to be responsible for chart cleaning and sanitizing. She indicated the Housekeeping Director was no longer employed at the facility and the Medical Record Director was new to her position. A5. On 8/21/12 at 8:00 A.M., the Administrator provided cleaning schedules, logs and delineated housekeeping responsibility forms to be used beginning in September. The Housekeeping Director was unavailable for interview. B.1. On initial tour of the kitchen on 8/14/12 at 11:00 A.M., the vinyl floor area which contained pan storage shelving and the vinyl flooring near the kitchen exit door had black debris along the floor edges of the room. The flooring in this area also had black soilage when a hand was swiped across the floor. On 8/14/12 at 11:31 A.M., the vinyl flooring in the food storage room was			

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	heavily soiled with a black debris and was sticky when a hand was swiped across it. From entry into the food storage room to the middle area of the room black tracking marks were observed. The FSM at this time indicated the floor was soiled. On 8/17/12 at 11:14 A.M., the flooring by the kitchen exit door and the flooring area which contained the pan storage, continued to have black soilage noted when a hand was swiped across it and black debris around the room floor edges. The FSM indicated the floor had been mopped, but further cleaning was needed. On 8/17/12 at 11:24 A.M., the food storage room floor still had black soilage when a hand was swept across the floor. The FSM indicated the floor had been mopped, but she feels like there was a wax build up. She indicated the floor cleaning used to be twice a week but not doing twice a week at present. She indicated there had also been a change in the floor care staff and the striping and the waxing procedures of the vinyl floor. On 8/20/12 at 10:37 A.M.,			

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	documentation from the FSM entitled, " Quick Kitchen Sanitation Rounds " was reviewed. This form indicated the dietary manager should look at the following items daily: " ... 5. Environment: floor is clean and without build up ... " This deficiency relates to complaint IN00113270. 3.1-19(f) 5-5.1(k)			